Exhibit 15

Mundy Pain Clinic P.C.
6240 Rashelle Drive, Suite 103
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Phone: 810-232-9800
Fax: 810-232-7710

INITIAL EVALUATION

Patient ID: 150
Patient Name:
Date of Birth:
Date of onset:
Date of Reevaluation: 04/20/10

CURRENT COMPLAINTS: MVA.

HISTORY OF PRESENT ILLNESS: This 56-year-old African-American female that ran a red light and was hit by the oncoming traffic on the driver side. She was a wearing a seatbelt. Airbags did not deploy. No loss of consciousness. The EMS came and took her to Hurley. They did x-rays and discharged home with whiplash. The patient had an x-ray in 2008 and that showed crushed her cervical vertebrae with bone replacement surgery. She had a pain all along the rib side this is much aggravated since the accident. Now, due to the accident this pain is severely worsened as it is attributed to be 8-10/10 of the cervical spine with radiation bilaterally that is sharp mostly to the right however greater on the left with finger paresthesias and the right shoulder is 10/10 with decreased range of motion. Thoracic spine is within normal limits. Lumbar spine is 6/10 and dull with radiation to the right back of the knee.

PAST MEDICAL HISTORY: High blood pressure.

CURRENT MEDICATIONS: Zanaflex, lisinopril, and HCTZ combination.

DRUG ALLERGIES: Penicillin, she gets rash.

PREVIOUS SURGERIES: Neck surgery from MVA 2008.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: She is separated. No alcohol or tobacco. She is disabled from 2008. A twelfth grade education.

PHYSICAL EXAMINATION: Vitals at the time of our examination. Blood pressure 128/86, respirations 16, pulse 82, 4 feet and 11 inches tall, and 135 pounds. In general: She is well nourished and developed and mild distress secondary to pain she is in. Awake, alert, and oriented x4. HEENT exam: Normocephalic and atraumatic. Pupils are equally, round and reactive to light and accommodation. Extraocular muscles are intact. The pulmonary exam clear to auscultation bilaterally. No wheezing, rales, or rhonchi. Abdomen: Soft, nontender, and nondistended. Bowel sounds x4 normoactive. Extremities: Musculoskeletal 5/5 in the muscle strength. Deep tendon reflexes 2/4. Pulses 2/4. Range of motion is full in the upper extremities.

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Decreased in the upper extremities and the right shoulder particularly approximately 30% and decreased in the lumbar spine in the lower extremities approximately 40% that are normal. Neurological exam, cervical spine was tender to palpation over the surgical scar that was noted as well as spinal processes of C5, C6, and C7. Thoracic spine was within normal limits. Lumbar spine was tender over the L3, L4, and L5. There was spasm noted in the cervical and lumbar spine. There was paraspinal moderate in nature. Muscle contraction and sensory, she was tender to palpation over C2 and C7 thoracic vertebrae and spinous processes of the lower levels. Lumbar spine was only of a spinous processes. Straight leg raise test was performed was positive on the left, 30 degrees in the right, 35% degrees cervical spine was positive for Spurling's to the right.

CURRENT DIAGNOSIS:
1. Cervical strain rule out radiculopathy.
2. Lumbar strain rule out radiculopathy.
3. Right shoulder derangement.

RECOMMENDATIONS:
1. PT x3 weeks for four weeks.
2. Medications Lortab 7.5/500 mg one p.o. b.i.d. #60. The patient is to continue Zanaflex prescribed by Dr. Resnick for the muscle relaxation.
3. Reevaluation will take in one month.

Martin Quiroga, D.O.

Transcribed by JJ Medical Systems
DD: 05/28/10
DT: 05/29/10
PTV/WF

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INITIAL EVALUATION

Patient ID: 3080
Patient Name:
Date of Birth:
Date of Injury: 04/23/2010
Date of Initial Evaluation: 05/20/2010

CHIEF COMPLAINT: MVA.

HISTORY OF PRESENT ILLNESS: This is a 49-year-old African-American female driver that was involved in a motor vehicle collision. She was rear ended at an unknown rate of speed but it was fast according to the patient while she was stopped at a red light. She was wearing a seatbelt. The airbags were not deployed though the vehicle was equipped. She did obtain a police report. EMS did not show up and nor did not go to the hospital. She states that she was shaken up by the accident quite a bit; however, her emotional state surpassed that of her physical complaint, so she opted to go home instead. When she woke up the next morning, she found herself to be in pain. Cervical pain was a 7/10 in quality and sharp quality, bilateral radiation with paresthesias upto the fingertips were noted. The thoracic spine was 7/10 and radiating to the right towards her chest around the flank. Her lumbar spine is worse, this is 10/10, sharp and bilateral radiation to the back of her knees. Additionally, the patient has had posttraumatic headaches approximately four episodes a week lasting one to two hours. These resolved only with excess use of over-the-counter medication for headaches.

REVIEW OF SYSTEMS: As per HPI.

MEDICATIONS: None.

ALLERGIES: Penicillin which gives her hives.

PRIOR INJURIES OR ACCIDENTS: None.

PRIOR SURGICAL PROCEDURES: She had a cesarean section x1.

PRIOR HOSPITALIZATIONS: None.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: She is married. Denies alcohol. Denies tobacco use. She works as a nursing home aide.

LAST DATE WORKED: Presently working.

EDUCATION: High school completion.

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Patient ID: 3080
Patient Name:
Date of Birth:
Date of Injury: 04/23/2010
Date of Initial Evaluation: 05/20/2010

PHYSICAL EXAMINATION: Vitals: She had a blood pressure of 136/84, pulse 72, and respirations 15. She is 5 feet 10 inches and weighs 149 pounds. General: Well nourished and developed, in no acute distress, alert and oriented x4. HEENT: Head is normocephalic and atraumatic. Pupils are equally round and reactive to light and accommodation. Extraocular muscles are intact. Cardiovascular: S1, S2. No murmurs, rubs, or gallops. Pulmonary: Clear to auscultation bilaterally. No wheezing, rales, or rhonchi. Abdomen: Soft, nontender, and nondistended. Bowel sounds x4, normoactive. Extremities: Full range of motion. No clubbing, cyanosis, or edema. Neurological Examination: Cervical spine palpation on the vertebral aspects of spinous processes and transverse processes revealed paraspinal musculature tenderness of a mild-to-moderate nature as well as spinous processes tenderness from C3 to C7 diffusely. Spurling's test was performed and it was positive bilateral up to the fingers with paresthesias. Rotation, flexion, extension of the cervical spine was reduced to approximately 40%. Sensation slightly decreased. Vibration intact. Thoracic spine examination was within normal limits. Lumbar spine examination, palpatory findings were that of moderate to severe paraspinal muscle spasm with tissue texture abnormality, asymmetry, restriction of motion, and tenderness to palpation along the spinous processes of L3, L4, and L5. Flexion and extension of lumbar spine was reduced to approximately 25%. Straight leg test was performed and was positive bilateral 30 and 35 degrees respectively, left and right. Muscle strength 5/5. Deep tendon reflexes 2/4. Gait was stable.

DIAGNOSES:
1. Cervical strain, rule out radiculopathy.
2. Thoracic strain, rule out radiculopathy.
3. Lumbar strain, rule out radiculopathy.
4. Posttraumatic headaches.

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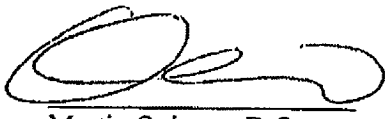
Patient ID: 3080
Patient Name:
Date of Birth:
Date of Injury: 04/23/2010
Date of Initial Evaluation: 05/20/2010

RECOMMENDATIONS:

1. Physical therapy and occupational therapy three sessions a week x4 weeks.
2. Pharmacotherapy with Valium 10 mg one p.o. t.i.d. #60 dispensed and pain medication with Lortab 7.5/500 mg one p.o. t.i.d. #90 dispensed. Additionally, the patient is to wear a lumbar brace which has been prescribed to her at this time and reevaluation to take place in 30 days. Physical therapy goals to restore motor deficits, increase range of motion, and reduction of pain.



Martin Quiroga, D.O.

Transcribed by JJ Medical Systems
DD: 08/05/10
DT: 08/06/10
PTV/WF/MW

EVALUATIONS

INITIAL EVALUATION

Date of Birth: 05/18/1956
Date of Injury: 06/03/2012

CHIEF COMPLAINT: Motor vehicle accident.

HISTORY OF PRESENT ILLNESS: This is a 56-year-old African American male who was the driver of a vehicle that struck the diver side of a car with its passenger side when he had to go around that car that was immediately making a right turn. Fortunately, the patient was wearing a seat belt. Air bags did not deploy. Police report was obtained. EMS failed to show at the scene. The patient went to his primary care physician a few days later, but no imaging was ordered and he was only given pain medications with instructions to wean it out. Today, he is still having pain that is cervical in nature, 8/10 and sharp, radiating to the right fingers with pain and paresthesias. Thoracic spine is within normal limits. Lumbar spine pain is 8/10, sharp, radiating to the right posterior thigh with pain and paresthesias. Gait is stable.

REVIEW OF SYSTEMS: As per HPI. Denies chest pain, shortness of breath, bowel or bladder issues, visual disturbances, or vertigo.

PAST MEDICAL HISTORY: Positive hypertension, hypercholesterolemia, and angina.

MEDICATIONS: Included Procardia 60 mg, simvastatin 20 mg, and HCTZ/hydrochlorothiazide 25 mg, all 1 p.o. q. daily.

PAST SURGICAL HISTORY: Right knee open reduction and internal fixation with plate.

ALLERGIES: No known drug allergies.

PRIOR INJURIES: The patient had a motor vehicle accident in 1987 with a right knee fracture at multiple places. This resulted in a right knee ORIF in that year, 1987.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: He is widowed with one child, a 34-year-old daughter. He is disabled since 2008 from his right knee injury. He was a forklift driver prior to this.

EDUCATION HISTORY: He is a high school graduate, no college.

PHYSICAL EXAM: Vitals: Blood pressure 140/88, heart rate 77, respirations 16, saturation of O2 at room air 99%, temperature is 98.5 degrees Fahrenheit. In general, he is well-nourished, well-developed, awake, alert, and oriented x4. HEENT: Normocephalic, atraumatic. Pupils are equally round and reactive to light and accommodation. Extraocular muscles are intact. Thyroid is within normal limits. Trachea is midline. No carotid bruits were auscultated. Cardiovascular: S1, S2, no murmurs, rubs, or gallops. Pulmonary: Clear to auscultation bilaterally. No wheezing, rales, or rhonchi. Abdomen: Soft, nontender, nondistended. Bowel sounds x4 are normoactive. No ecchymosis noted. Masses palpated none. Extremities: Full range of motion without clubbing, cyanosis, or edema. Neurologic: Cranial nerves II-XII are grossly intact. No focal deficit. No pronator drift to Barre's. Romberg's sign is negative. Babinski's reflex is absent. Deep tendon reflexes are 2/4 and pulses are 2/4 diffusely. Musculoskeletal: Cervical is positive for tissue texture abnormality, asymmetry, restriction of motion, and tenderness to palpation along the spinous processes between C4-C7. Bilateral paraspinal spams are present and moderate, worse on the left. Vibration and pinprick are intact. Flexion and extension was 1 fingerbreadth on chin-to-chest. Spurling's test was performed and was positive in neutral and positive in extended position on the left sdie. The thoracic spine was within normal limits. No muscle spasms, motor deficits, or tenderness to palpation. Lumbar spine, however, was positive for tenderness along the spinous process between L2-L5 with bilateral paraspinal muscle spasms, the right greater than the left. Straight leg test, however, was performed and was negative bilaterally. Gait is stable. Flexion and extension of the lumbar spine was decreased 10% secondary to the pain in active phase while rotation was within normal limits.

IMPRESSION:
1. Status post motor vehicle accident.
2. Cervicalgia with muscle spasm.
3. Cervical strain, rule out radiculopathy.
4. Lumbago with muscle spasm.
5. Lumbar strain, rule out radiculopathy.

RECOMMENDATIONS:
1. I recommended the patient undergo physical therapy program three sessions a week x4 weeks.
2. The patient will be given pharmacotherapy in the form of Vicodin ES 1 p.o. b.i.d. #60 for pain alleviation, and Valium 10 mg 1 p.o. b.i.d. #60 for muscle relaxation, no refills on both.
3. Reevaluation will take place in four weeks.
4. Therapeutic and pharmacological goals will be restoration of motor deficits, reduction of pain, and increase in range of motion.

11272012

Martin Quiroga, DO

11272012

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MEDICAL RE-EVALUATION

Patient ID: 150
Patient Name: [redacted]
Date of Birth:
Date of Injury:
Date of Reevaluation: 12/14/2010

CURRENT COMPLAINTS: The patient is still having cervical pain 7/10, sharp, radiating bilaterally to the fingers with exquisite pain and paraesthesias. She has thoracic pain, 8/10, dull and nonradiating. Her lumbar pain is 7/10, sharp with bilateral radiation to the neck and knees. She has been compliant to physical therapy and pharmacotherapy, but not improved right shoulder, which she has somewhat diminished, is still present however at 6/10, sharp, and focal with decreased range of motion being the biggest complaint and it is difficult for the patient to move his arm around. The patient has had MRI and EMG. The MRI shows disc bulge at C4-C5, C5-C6 and a focal right paracentral disc bulge with effacement of ventral subarachnoid space consistent with her complaints. The lumbar spine also shows bilateral facet arthrosis and ligamentum flavum hypertrophy and L2-L3, L3-L4, and L4-L5 shows diffuse disc bulge at central narrowing with annular tear.

OBJECTIVE FINDINGS: Cervical spine was positive for tissue texture abnormality, asymmetry, restriction of motion, and tenderness to palpation of the spinous process of C4 through C7. Paraspinal muscle tenderness was moderate. Chin-to-chest test was reduced to one fingerbreadth and rotation decreased to 20%. Spurling's test was positive on the right. Paraspinal muscle spasm was moderate. Thoracic spine was positive for mild paraspinal muscle spasms with tender points at T7 through T10 spinous processes. This was exquisitely tender to palpation. The rotation was decreased to 20%. Lumbar spine was positive for paraspinal muscle spasms severe in nature. Tender points on spinous process from L2 through L5. Paraspinal muscle spams were severe. Straight leg test was positive 30 degrees on the right and 45 degrees on the left. Flexion was reduced to 40% and rotation to 20%. Gait was stable. Muscle strength 5/5. Deep tendon reflexes were 2/4. Pulses were 2/4 with exception of the right shoulder, which was muscle strength at 4/5. Decreased range of motion and abduction to 40% and adduction to 30%, rest is normal. Neer sign and Hawkins sign were both positive. The area was warm to the touch. Vibration and pinprick were intact.

TESTING AND CONSULTATIONS: MRI of the lumbar spine shows annular tear at L4-L5 with diffuse disc bulge and foraminal bilateral wearing at L5-S1 as well as cervical disc bulge diffuse at C5-C6 and C4-C5. She was scheduled to undergo manipulation under anesthesia on this Saturday on December 18, 2010 with epidural steroid injection of the lumbar spine, the lumbar series will be conducted first and then cervical series.

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MEDICAL RE-EVALUATION

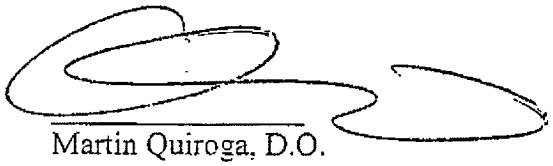
Patient ID: 150
Patient Name: [redacted]
Date of Birth:
Date of Injury:
Date of Reevaluation: 12/14/2010

DIAGNOSES:

1. Status post MVA, February 5, 2010.
2. Cervical radiculopathy.
3. Lumbar radiculopathy.
4. Right shoulder derangement.
5. Somatic dysfunction of cervical, thoracic, and lumbar spine.

RECOMMENDATIONS:

1. Manipulation under anesthesia on Saturday with epidural steroid injection and PRP of the right shoulder.
2. Continue physical therapy three sessions a week x4 weeks.
3. Pharmacotherapy to be continued for this patient as previously prescribed.
4. Reevaluation will take place in 30 days.
5. Physical therapy goals will be restoration of motor deficits, reduction in pain, and increased range of motion.



Martin Quiroga, D.O.

Transcribed by JJ Medical Systems
DD: 12/14/10
DT: 12/15/10
AJ/pn

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FOLLOWUP VISIT

Patient ID: 5800
Patient Name:
Date of Birth:
Date of Injury: 04/06/2011
Date of Reevaluation: 05/19/2011

CURRENT COMPLAINTS/HISTORY OF PRESENT ILLNESS: The patient comes in for a followup examination. She is complaining of cervical pain 9/10 and sharp with bilateral radiation and tingling down to the hands with pain and paraesthesia. Thoracic pain is 7/10, dull and non-radiating. Lumbar pain is 8/10 and sharp radiating to the left back of the knee region. She is still complaining daily headaches. The bilateral shoulders pain appeared to be independent as well, at the time rated as 6/10 with decreased flexion and extension and internal and external rotation. The patient reminds me that she has had a broken neck in 1995, for which a fusion was performed. A bone graft for the fusion was taken from the left hip. This was previous asymptomatic, but since the motor vehicle accident, her left hip pain where the bone graft was taken has started causing her pain.

OBJECTIVE FINDINGS: Vitals are within normal limits. Heart, S1 and S2. No murmurs, rubs, or gallops. Lungs are clear to auscultation bilaterally. No wheezing, rales, or rhonchi. The musculoskeletal exam reveals positive tissue texture abnormality of cervical spine with asymmetry, restriction of motion, and tenderness to palpation of spinous process at C2 through C7. Spurling test was positive bilaterally. Flexion and extension was one fingerbreadth on chin-to-chest. Vibration and pinprick were intact. The thoracic spine was positive for tender points between T5 and T10 spinous process with bilateral paraspinal muscle spasms. The lumbar spine was positive for L2 through L5 spinous processes tenderness with bilateral paraspinal muscle spasms. Straight leg test was performed and was positive bilaterally, 30 degrees on the left and 40 degrees on the right. The flexion and extension was reduced 20% secondary to pain and rotation was full in range of motion. Neurological exam, cranial nerves II through XII are grossly intact. No focal deficits. No pronator drift or Barré. Romberg sign was negative. Babinski reflex was absent. Deep tendon reflexes were 2/4.

TESTINGS AND CONSULTATIONS: We will order an MRI of the cervical, thoracic, and lumbar spine, bilateral shoulders and brain MRI to rule out TBI secondary to concussive headaches.

IMPRESSION:
1. Status post motor vehicle accident.
2. Cervicalgia with muscle spasm.
3. Cervical strain, rule out radiculopathy.
4. Thoracic pain with muscle spasm.
5. Thoracic strain, rule out radiculopathy.
6. Low back pain/lumbago with muscle spasm.

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FOLLOWUP VISIT

Patient ID: 5800
Patient Name:
Date of Birth:
Date of Injury: 04/06/2011
Date of Reevaluation: 05/19/2011

7. Lumbar strain, rule out radiculopathy.
8. Postconcussive headaches, rule out traumatic brain injury.
9. Bilateral shoulder pain with strain, rule out derangement.

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FOLLOWUP VISIT

Patient ID: 5800
Patient Name:
Date of Birth:
Date of Injury: 04/06/2011
Date of Reevaluation: 05/19/2011

RECOMMENDATIONS:

1. The patient is recommended to discontinue Vicodin at this time as is not working. We will replace with Lortab 10/500 mg one p.o. b.i.d. #90 for pain alleviation. She will continue Valium 10 mg one p.o. b.i.d. #60 for muscle relaxation.
2. She will continue with therapy as indicated with physical therapy three sessions a week x4 weeks.
3. She will be ordered for an MRI of bilateral shoulders as well MRI of the brain to rule out internal derangement and TBI.
4. An MRI will also be ordered for cervical, thoracic, and lumbar spine to rule out radiculopathy.
5. Reevaluation will take place in 30 days.
6. Therapeutic goals will be restoration of motor deficits, reduction of pain, and increased range of motion.

Martin Quiroga, D.O.

Transcribed by JJ Medical Systems
DD: 05/19/11
DT: 05/20/11
BS

EVALUATIONS

DOB: 07/12/1947

CHIEF COMPLAINT: Motor vehicle accident.

HISTORY OF PRESENT ILLNESS: This is a 65-year-old African American male driver who was hit in the right front side of his vehicle at the intersection. Fortunately, he was wearing a seat belt. The airbags deployed and a police report was obtained. EMS showed up and took the patient to Hurley where he was evaluated for approximately 3-4 hours. He was sent to home after negative imaging, however, but had continued in pain, worsening progressively. Today, he is complaining of cervical pain, 9/10, sharp, radiating to the left arm with pain and paresthesia. Thoracic pain is 8/10, dull, nonradiating, and lumbar pain is 7/10, sharp, radiating to the left leg with pain and paresthesia. The patient is also complaining of headaches daily. On a visual pain analog scale, he rates them as 8/10. They are occipital and parietal in location and all of these have been occurring since the motor vehicle accident. He never had these symptoms before.

REVIEW OF SYSTEMS: As per HPI.

PAST MEDICAL HISTORY: Hypertension, diabetes mellitus, hypercholesterolemia, and alcohol abuse, but he quit two years ago.

PAST SURGICAL HISTORY: Gunshot wound in 1976 with open laparotomy for damage control surgery and repair subsequently.

CURRENT MEDICATIONS: Vicodin and soma. The patient cannot remember any of the other medications, but does remember those two. I asked him about hypertension medications, he did not remember; diabetes medications, he did not remember; cholesterol medications, he did not remember.

DRUG ALLERGIES: No known drug allergies.

PRIOR INJURIES OR ACCIDENTS: Gunshot wound in 1976.

PRIOR SURGICAL PROCEDURES: Damage control with trauma surgery and laparotomy for control of gunshot wound in 1976.

PRIOR HOSPITALIZATIONS: As above.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: He is a widow.

WORK HISTORY: He is currently unemployed, has disability due to gunshot wound to the chest with bilateral chest tubes causing breathing problems. This is likely due to fibrosis.

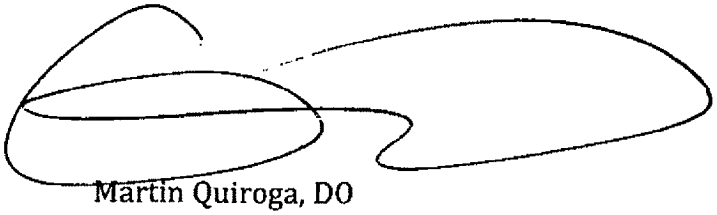
REVIEW OF SYSTEMS: As per HPI.

PHYSICAL EXAM: Vitals, blood pressure 146/92, heart rate 84, respirations 18, saturation of O2 at room air 96%, temperature is 98.7 degrees Fahrenheit. He is 5 feet 9 inches tall and weighs 192 pounds. In general, he is well-nourished, well-developed, awake, alert, and oriented x4. HEENT exam, normocephalic, atraumatic. Pupils are equally round and reactive to light and accommodation. Extraocular muscles are intact. Thyroid is within normal limits. Trachea is midline. No carotid bruits were auscultated. Cardiovascular exam, S1, S2, no murmurs, rubs, or gallops, no S3 or S4, rate is regular. Pulmonary exam, clear to auscultation bilaterally. No wheezing, rales, or rhonchi. The abdomen is soft, nontender, nondistended. Bowel sounds x4 are normoactive. Midline surgical incisional scar noted consistent with laparotomy many years ago. No ecchymosis noted, no masses palpated, no abdominal or renal bruits auscultated. Neurological exam, cranial nerves II through XII are grossly intact. No focal deficit. No pronator drift to Barre's. Romberg's sign is negative. Babinski's reflex is absent. Deep tendon reflexes are 2/4. Extremities, full range of motion without clubbing, cyanosis, or edema. Muscle strength 5/5, pulses are 2/4. Musculoskeletal exam reveals cervical spine with mild tissue texture abnormality, asymmetry, restriction of motion, and tenderness to palpation of the spinous process of C5-C7 with negative Spurling's test in neutral and extended positions. Flexion and extension was 1 fingerbreadth on chin-to-chest and vibration and pinprick was intact. Thoracic spine was also positive for mild tender points along spinous process of T6-T10 with bilateral paraspinal muscle spasms, left greater than right. Flexion, extension, side-bending, and rotation were all within normal limits. Vibration and pinprick was intact. Lumbar spine is positive for moderate paraspinal muscle spasm with L2-L5 spinous process tenderness and straight leg test is positive bilaterally at 40 degrees. Vibration and pinprick is intact. Flexion and extension reduction is 10% and 5% respectively. Rotation and side-bending are within normal limits. Gait is stable.

IMPRESSION:
1. Status post motor vehicle accident.
2. Cervicalgia with muscle spasm.
3. Cervical strain, rule out radiculopathy.
4. Thoracic pain with muscle spasm.
5. Thoracic strain, rule out radiculopathy.
6. Low back pain/lumbago with muscle spasm.
7. Lumbar strain, rule out radiculopathy.
8. Postconcussive headaches, rule out traumatic brain injury.

RECOMMENDATIONS:
1. MRI of the head to rule out rule out traumatic brain injury.

2. Physical therapy 3 sessions a week x4 weeks.
3. Pharmacotherapy will be give for this patient with soma 350 mg 1 p.o. q.h.s. #30 for muscle relaxation, and Ultram 50 mg 1 p.o. b.i.d. #60 for pain alleviation.
4. Reevaluation will take place in 30 days.
5. Therapeutic and pharmacological goals will be restoration of motor deficit, reduction of pain, and increase range of motion.



Martin Quiroga, DO